Statistical Bulletin

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Rapid Suburban Population Growth

THE suburbs continue to grow at a faster rate than other areas of the United States. Between April 1950 and July 1958, about 12.4 million people were added to the population of communities adjacent to our larger cities, an increase averaging 3.7 percent annually. This is almost three times the rate of growth within these cities and more than double that for the country as a whole. The population growth since 1940 in the central cities and in the outlying parts of the 168 standard metropolitan areas* is shown in the table on page 2; in addition to summary figures for the various geographic divisions, details are shown for individual areas with 500,000 or more population in 1950, and for areas with at least 250,000 persons in the central city.

Every geographic division of the country has shared in the rapid suburban population growth. In most suburban areas, the rate of increase has been greater in recent years than in the 1940's. The suburbs in the West continue to record the largest gains. Since April 1950, the rate of suburban growth in the Mountain division and along the Pacific Coast has exceeded 5 percent annually. Most striking is the increase around Denver, the population outside that city more than doubling in about eight years. The communities adjacent to San Diego have grown almost as rapidly—by 8 percent a year. Four areas outside the West have also had outstanding records; the population has increased by more than 6 percent annually in the suburbs of Detroit, Ft. Worth, District of Columbia, and Baltimore.

Although population gains have been less marked in urban centers than in the suburbs, a number of large cities have experienced exceptional growth. Houston led all major cities in this respect, with a population increase exceeding 5 percent annually—expanding from 596,000 residents in 1950 to about 910,000 in 1958. Atlanta, Dallas, and San Diego also show increases of about the same relative magnitude. In all four of these cities, as

*Defined in the footnote to the table on the next page.

POPULATION INCREASE INSIDE AND OUTSIDE OF CENTRAL CITIES

Standard Metropolitan Areas by Geographic Division, United States, 1940-1958

Standard Metropolitan Area	Central City			Outside of Central City		
	Population 1958 (1,000's)	Annual Percent Increase*		Population 1958 (1,000's)	Annual Percent Increase*	
		1950-1958	1940-1950		1950-1958	1940-1950
United States	54,808	1.3	1.3	47,444	3.7	3.1
New England	3,008	.1	.4	3,617	1.8	1.5
Boston, Mass.	736	−1.0	.4	1,709	1.0	1.1
Providence, R. I.	236	− .6	− .2	576	2.0	1.4
Other	2,036	.6	.6	1,332	2.7	2.2
Middle Atlantic	14,352	.1	.5	13,423	3.0	1.7
Albany-Schenectady-Troy, N. Y.	316	.7	.4	278	3.2	1.9
Buffalo, N. Y.	599	.4	.1	742	4.7	2.9
New York-Northeastern New Jersey	8,632†	‡	.5	5,880	3.9	2.1
Philadelphia, Pa.	2,108	.2	.7	2,129	3.5	2.3
Pittsburgh, Pa.	663	− .3	.1	1,668	1.0	.9
Rochester, N. Y.	349	.6	.2	246	5.7	3.3
Other	1,685	.1	.2	2,480	1.3	.8
East North Central	12,605	1.1	.9	9,657	4.2	3.2
Akron, Ohio	306	1.3	1.2	184	3.8	3.7
Chicago, Ill.	3,770	.5	.6	2,700	4.5	2.7
Cincinnati, Ohio	571	1.5	1.0	482	2.3	1.9
Cleveland, Ohio	926	.1	.4	836	5.2	3.5
Columbus, Ohio	472	2.8	2.1	189	4.9	4.3
Detroit, Mich.	1,900	.3	1.3	1,940	6.4	4.5
Indianapolis, Ind.	462	1.0	1.0	192	5.3	5.4
Milwaukee, Wis.	725	1.6	.8	356	5.2	2.7
Toledo, Ohio	340	1.4	.8	125	3.8	4.0
Youngstown, Ohio	185	1.2	‡	429	2.1	1.6
Other	2,948	2.1	1.2	2,224	2.6	3.3
West North Central	4,088	1.4	1.0	2,729	3.4	2.7
Kansas City, Mo.	524	1.7	1.4	482	3.7	2.2
Minneapolis-St. Paul, Minn.	906	1.0	.7	427	5.1	5.8
Omaha, Nebr.	300	2.2	1.1	128	1.3	1.3
St. Louis, Mo.	861	.1	.5	1,108	3.7	3.0
Other	1,497	2.3	1.4	584	1.9	1.7
South Atlantic	5,612	1.6	1.8	5,740	4.5	4.4
Atlanta, Ga.	496	5.0	.9	363	.8	4.7
Baltimore, Md.	982	.4	1.0	632	5.1	5.6
Norfolk-Portsmouth, Va.	386	3.4	4.2	197	3.2	9.0
Washington, D. C.	825	.3	1.9	1,087	6.2	8.1
Other	2,923	1.8	2.0	3,461	4.3	3.3
East South Central	2,288	1.9	2.1	1,547	2.5	3.4
Birmingham, Ala.	370	1.5	2.0	271	1.8	2.0
Louisville, Ky.	418	1.5	1.5	295	4.3	4.7
Memphis, Tenn.	459	1.8	3.1	126	4.7	2.8
Other	1,041	2.1	2.1	855	1.8	3.6
West South Central	5,528	3.7	3.7	1,713	3.1	3.3
Dallas, Texas	647	5.0	3.9	188	.5	5.7
Fort Worth, Texas	399	4.4	4.6	136	6.3	5.5
Houston, Texas	910	5.3	4.5	315	5.0	3.9
New Orleans, La.	601	.6	1.4	148	3.1	7.3
San Antonio, Texas	541	3.5	4.9	97	.6	.9
Other	2,430	3.6	3.9	829	3.0	2.2
Mountain	1,324	4.5	3.3	901	5.8	5.5
Denver, Colo.	522	2.8	2.6	304	9.1	5.6
Other	802	5.7	3.8	597	4.4	5.5
Pacific	6,003	2.1	2.7	8,117	5.2	6.1
Los Angeles, Calif.	2,381	2.3	2.7	3,829	5.8	5.4
Portland, Ore.	402	.9	2.1	425	3.1	5.4
San Diego, Calif.	500	5.0	5.1	420	8.0	10.0
San Francisco-Oakland, Calif.	1,175	.2	2.2	1,455	3.7	7.5
Seattle, Wash.	576	2.5	2.4	297	1.4	6.8
Other	969	2.9	3.0	1,691	5.8	5.8

*Geometric average annual rate. Minus sign (−) denotes decrease.
†Includes Jersey City and Newark. ‡Less than 0.05 percent.

Note: Data relate to the 168 areas in the United States as constituted in 1950; each area is a county, or group of contiguous counties, which contained at least one city of 50,000 inhabitants or more.

Source: April 1 of 1940 and 1950, from the decennial censuses; July 1, 1958, from special censuses, estimates by State and local agencies, and estimates by the Statistical Bureau of the Metropolitan Life Insurance Company

well as in several others, the gains resulted in varying degree from the expansion of city boundaries, with a compensating contraction of that part of the metropolitan area lying outside the city.

Among the 10 most populous cities in 1950, only Los Angeles has had a substantial growth, its population rising 2.3 percent a year —from 1,970,000 in 1950 to about 2,380,000 in 1958. In the others, the annual rate of increase has been 0.5 percent or less; Boston's population has actually decreased 1.0 percent a year. Two other large cities in the Northeast—Providence and Pittsburgh — have also sustained population losses. In fact, urban population growth has virtually come to a halt throughout most of New England and the Middle Atlantic States. On the other hand, the suburban areas around some of these cities have recorded substantial population gains, as is evident from the table. For example, while there has been no appreciable population change in New York City, Jersey City, and Newark, the adjacent communities have increased 3.9 percent a year. As a result, 1.6 million persons have been added to the New York-Northeastern New Jersey standard metropolitan area—a gain which is exceeded only by the increase in the Los Angeles area.

The 168 standard metropolitan areas have slowly but steadily increased their share of the country's population. In July 1958 these areas included more than 102 million residents, or 59 percent of the total population in the United States; at the time of the 1950 Census the proportion was 56 percent. The suburban population as a proportion of the total metropolitan population increased from 41.5 percent in 1950 to 46.4 percent in 1958. Moreover, in several parts of the country, particularly in the Pacific States and in New England, suburbanites now outnumber the city dwellers by a considerable margin.

Hospitalization at the Older Ages

At ages 60 and over, the hospital admission rate for men is appreciably greater than that for women, but the average duration of stay is much higher for the women. When both the incidence of hospitalization and the average length of stay per case are taken into account, it is found that women utilize hospital service slightly more than the men do. These facts emerge from a study of the experience of the Metropolitan Life Insurance Company office and field personnel protected under the Company's Group insurance program.* This study includes not only office and field personnel actively at work but also the permanently disabled and the retired. The experience covered cases

*The study does not include personnel in the Pacific Coast States and in Canada.

admitted to a hospital in 1957 and 1958 and traced to June 30, 1959. In interpreting the findings, it should be borne in mind that they relate to insurance company personnel protected under a liberal hospitalization insurance program.

As Table 1 shows, nearly one sixth of the men and about one tenth of the women at ages 60 and over were hospitalized annually. The yearly hospitalization rate among males rose, although not steadily, from 159 per 1,000 at ages 60-64 to 185 per 1,000 at ages 75 and over. In each age group, a somewhat greater number of men were hospitalized for nonsurgical than for surgical conditions. The two types of cases were about equal in frequency among women at ages 60 and over, the higher incidence

TABLE 1—HOSPITAL ADMISSION RATE AND DURATION OF STAY AT AGES 60 AND OVER

by Sex, Insured Personnel of Metropolitan Life Insurance Company*

Surgical and Nonsurgical Conditions

Cases Admitted January 1, 1957 to December 31, 1958 and Traced to June 30, 1959†

Age Group (Years)	Annual Hospital Admissions per 1,000 Insured		Average Duration of Hospital Stay			
			Days per Case		Days per Person Insured	
	Male	Female	Male	Female	Male	Female
	Surgical and Nonsurgical Conditions—Total					
Ages 60 and Over	156	98	16.8	27.8	2.6	2.7
60–64	159	73	13.3	16.3	2.1	1.2
65–74	144	108	17.2	29.0	2.5	2.9
75 and over	185	137	24.6	37.5	4.5	5.2
	Surgical Conditions					
Ages 60 and Over	72	49	15.9	25.3	1.1	1.2
60–64	72	45	13.7	15.4	1.0	0.7
65–74	69	49	17.1	24.8	1.2	1.2
75 and over	79	57	18.9	41.2	1.5	2.4
	Nonsurgical Conditions					
Ages 60 and Over	84	48	17.5	30.3	1.5	1.5
60–64	87	28	13.0	17.7	1.1	0.5
65–74	75	59	17.3	33.0	1.3	1.7
75 and over	106	80	28.8	34.8	3.1	2.8

*Includes persons actively at work, those on total and permanent disability, and the retired; personnel in the Pacific Coast States and Canada are not included.

†A total of 2,361 men and 357 women were admitted in the two years.

of surgical cases at ages 60-64 being balanced by the preponderance of nonsurgical cases at ages 65 and over.

The duration of hospitalization per case increased steadily with advance in age among both the men and women, and for surgical as well as for nonsurgical conditions. Among males, the average stay per case for all causes combined increased from 13.3 days at ages 60-64 to 24.6 days at ages 75 and over. Among the women, the average rose correspondingly from 16.3 to 37.5 days. Women hospitalized for surgical conditions stayed an average of 25.3 days, compared with 15.9 days for males; for nonsurgical conditions the averages were 30.3 and 17.5 days, respectively.

The total time spent in the hospital by the male patients in this study was equivalent to 2.6 days of hospital utilization a year for the average man at ages 60 and over insured under the Company's program; for the women the comparable figure was 2.7 days a year. These figures obviously are much lower than those based on hospitalized cases alone.

Table 2 shows the leading conditions for which personnel were hospitalized. Among males, abdominal and urologic operations accounted for nearly three fifths of all surgical cases. Herniotomies were by far the leading type of abdominal operation, comprising 1 out of every 8 surgical cases among males. Prostatectomies and cystoscopies, approximately equal in frequency, together accounted for about 3 out of every 4 urologic operations. Other leading types of surgery among men were the removal of benign tumors, proctologic operations, eye surgery, and the reduction of fractures.

The relative frequency of nonsurgical conditions for which the insured men were hospitalized is shown in the lower tier of Table 2. Heart disease accounted for one third of these cases; nearly every second case of heart disease was reported as due to coronary artery disease. Almost as many men were hospitalized for digestive disorders as for coronary artery disease. Ranking next in order of frequency were respiratory conditions, circulatory conditions other than heart, and diseases of the central nervous system.

The average length of hospital stay for the men in this study varied with the condition for which they were hospitalized. Orthopedic surgery and operations of the ear, nose, and throat required a shorter stay than any of the other surgical conditions shown in the table—about 7 days per case. On the other hand, cancer and fractures were responsible for the longest periods of stay for men hospitalized with surgical conditions, namely, about 31 days and 26 days per case, respectively; data available separately for fractures of the hip and pelvis show an average hospital

TABLE 2—LEADING CAUSES OF HOSPITALIZATION AND AVERAGE DURATION OF HOSPITAL STAY AT AGES 60 YEARS AND OVER

By Sex. Insured Personnel of Metropolitan Life Insurance Company*
Cases Admitted January 1, 1957 to December 31, 1958 and Traced to June 30, 1959†

Type of Case	Male		Female	
	Cases per 1,000 Insured	Average Hospital Stay, in Days	Cases per 1,000 Insured	Average Hospital Stay, in Days
Surgical Conditions—Total	71.8	15.9	49.3	25.3
Abdominal surgery	20.9	15.3	10.5	27.3
Herniotomy (all types)	9.2	10.3	‡	‡
Gallbladder	2.6	20.1	‡	‡
Gastrectomies and gastrotomies	1.9	21.2	‡	‡
Urologic surgery	19.6	18.1	2.7	17.0
Prostatectomies	7.9	23.0	—	—
Cystoscopies	7.4	13.7	‡	‡
Benign tumors	5.2	11.0	5.2	10.0
Proctologic surgery	4.8	11.4	3.6	14.5
Hemorrhoids	2.7	8.3	‡	‡
Eye	4.3	11.6	5.5	12.5
Cataracts	2.6	10.6	3.8	14.7
Fractures	2.9	25.5	8.5	45.1
Fractures of hip and pelvis	1.3	35.7	4.4	69.3
Thoracic surgery	2.3	18.0	‡	‡
Cancer	2.2	31.4	2.7	36.1
Infections and traumata	2.2	9.9	‡	‡
Ear, nose, and throat	1.9	7.1	‡	‡
Neurosurgery	1.5	26.0	‡	‡
Orthopedic surgery	1.3	7.0	‡	‡
Gynecologic surgery	—	—	4.1	14.3
All other	2.7	15.0	‡	‡
Nonsurgical Conditions—Total	84.3	17.5	48.5	30.3
Diseases of heart	28.5	20.0	12.3	22.5
Coronary arteries	13.4	18.8	3.6	31.6
Diseases of digestive system	12.8	8.7	6.0	14.5
Diseases of respiratory system	7.5	11.4	6.3	22.7
Diseases of circulatory system, except heart	6.4	11.3	4.4	52.3
Diseases of central nervous system	4.8	20.2	3.6	19.7
Diabetes	3.3	13.2	‡	‡
Diseases of genito-urinary system	2.7	11.3	‡	‡
Accidents	2.6	13.4	3.6	30.1
Psychoneuroses and psychoses	2.3	107.5	‡	‡
Arthritis	2.1	8.5	‡	‡
Cancer	2.0	29.8	‡	‡
Benign tumors	‡	‡	‡	‡
All other	9.0	11.1	4.4	15.1

*Includes persons actively at work, those on total and permanent disability, and the retired; personnel in the Pacific Coast States and Canada are not included.
†A total of 2,361 men and 357 women were admitted in the two years.
‡Less than ten cases.

stay of nearly 36 days per case.

Nearly two fifths of the total time that the men in this study spent in the hospital for nonsurgical conditions was for heart disease. Men hospitalized for this disease stayed an average of 20 days; for coronary artery disease alone the average duration of hospitalization was only a little shorter. The men admitted to hospitals for psychoneuroses and psychoses stayed an average of about 108 days—longer than for any other disease, surgical or nonsurgical. Although psychoneuroses and psychoses accounted for only 3 percent of nonsurgical cases among men at ages 60 and over, these disorders were responsible for 17 percent of the time that men spent in the hospital for nonsurgical conditions.

Inasmuch as the number of women in this study is relatively small, no detailed analysis was made of their experience. In general, their pattern of hospitalization has many points in common with that for the men. For example, among the women as well as the men, abdominal operations were the leading type of surgical condition and heart disease the most frequent cause of hospitalization for nonsurgical conditions. The details are shown in the right-hand panel of Table 2.

Hearing Impairment Is Common

THE current National Health Survey indicates that there are about 5,800,000 people in the United States with some degree of hearing impairment; of this total nearly 110,000 are reported to be totally deaf. Hearing difficulties are more common among males than among females. Forty out of every 1,000 males are reported to have impaired hearing, a rate one third higher than that for females. The higher prevalence rate among males reflects their more frequent involvement in accidents and their greater exposure to prolonged intense noise in industry. One fifth of the hearing impairments among males result from injury, whereas among females the proportion is only about one twenty-fifth.

The relative frequency of hearing impairments rises rapidly with advance in age, as the table on the next page shows. From 8 per 1,000 persons under 25, the rate rises to nearly 130 per 1,000 at ages 65-74, and to about twice that figure at ages 75 and over. More than two fifths of the people with impaired hearing are at ages 65 and over, which age group constitutes one twelfth of the total population. Nevertheless, impaired hearing is also an important health problem at the younger ages; it affects well over a half million of the people under age 25 and nearly one million in the age group 25-44 years.

Detection of hearing impairments is particularly difficult among children of preschool age, inasmuch as

FREQUENCY OF HEARING IMPAIRMENT

By age. U. S. National Health Survey
July 1957-June 1958

Age Period (Years)	Number of Cases	Rate per 1,000 Persons
All Ages	5,822,000	34.6
Under 25	583,000	7.9
25–44	941,000	20.6
45–64	1,801,000	52.2
65–74	1,244,000	129.2
75 and over	1,253,000	256.4

Note: Data refer to civilian noninstitutional population, and include total deafness.

Source: *United States National Health Survey*, Series B-9, 1959, p. 9.

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the usual means of screening for hearing loss are not considered efficient for very young children. A recent study in Rochester, utilizing special means of detection, showed that 6½ percent of the children from 2½ through 5½ years of age were considered to have an appreciable hearing loss. Early case finding is particularly advantageous among preschool children, since speech training is most effective when begun before the child is of school age.

Some indication of the extent of seriously impaired hearing among children is available from data regarding persons under age 21 who received care for this condition under the Crippled Children's Program of the Social Security Act. In 1957, more than 17,000 children received physician's services for impaired hearing and deafness in 28 States which included these conditions in their programs.

Marked impairments of hearing or deafness apparently do not adversely affect mortality. In a long-term follow-up study of persons with such defects found upon examination for Life insurance, the mortality experienced was no higher than that for persons insured at standard premium rates. This may reflect, in part, the fact that people with such impairments probably live more sheltered lives than the average person. Only in cases involving mutism was the mortality increased, being nearly 1½ times as high as the average for standard risks.

Much can be done to correct hearing impairments and to prevent deafness. Many of the hearing difficulties at the younger ages result from infection or accidents; these difficulties can be diagnosed and treated early. A nationwide program for the detection of hearing loss among school-age children, coupled with measures for medical referral and follow-up, might accomplish much in reducing or at least ameliorating hearing impairments. The considerable research now being done on the relation of infection in the mother during the first months of pregnancy to congenital anomalies may throw light on the origin of some hearing impairments present at birth.

Relatively few comprehensive studies are available on the effects of noise in industry. The relation

of hearing loss to noise exposure has not yet been evaluated to permit the setting of a safe level of noise exposure in industry. Further research is needed in this field.

Greater efforts should be made toward motivating people with hearing impairments to seek early medical attention. Hearing should be checked as part of periodic health examinations for people at every stage of life. This would permit not only better treatment but also more effective rehabilitation with suitable hearing aids where indicated. In recent years, surgery has improved hearing for many people in middle and later life afflicted with chronic progressive deafness.

Note: Among the sources used were the following: *Health Statistics From the United States National Health Survey*, "Impairments By Type, Sex and Age," Series B-9, April 1959; Geyer, M. L., and Yankauer, A., "Detection of Hearing Loss in Preschool Children," *Public Health Reports*, August 1957, p. 723; Gringas, W., Summerfield, A., and Glorig, A., "Hearing Loss in Relation to Industrial Noise-Exposure," *Industrial Medicine and Surgery*, October 1957, p. 451; *1951 Impairment Study*, Society of Actuaries, April 1954, p. 258.

Mortality and Social Class*

It has long been recognized that people in the higher social classes, as indicated by occupation, have an appreciably lower mortality than those at the lower end of the social scale. The principal source of data on this matter are the decennial reports on occupational mortality by the Registrar General of England and Wales. The most recent of these reports relates to the five-year period 1949-53, centering around the census year 1951. The large number of occupations included in this report are grouped into the five social classes shown in the table on page 10, where a comparison is made with like data for 1930-32.

Whereas Social Class I had the most favorable mortality in 1930-32, the advantage shifted to Social Class II in the more recent study. In the 1930-32 investigation, the Standardized Mortality Ratio among men 20-64 years of age increased progressively from 90 in Social Class I to 111 among those in Social Class V. In 1949-53, however, the Mortality Ratio decreased from 100 in Social Class I to 90 in Social Class II, and then rose without interruption to 118 in Social Class V. (For definition of Standardized Mortality Ratio see footnote to the table.)

The differences in mortality among men in the various social classes reflect largely the social and economic factors associated with their standard of living, and, in general, only to a limited extent the specific hazards incidental to occupation. To assess the effect of general environmental factors alone, the Registrar General

*This article is based upon a paper, "The Occupational Mortality Study by the Registrar General of England and Wales," presented by Jules V. Quint of the Statistical Bureau, Metropolitan Life Insurance Company, at the annual meeting of Home Office Life Underwriters Association, May 13, 1959.

STANDARDIZED MORTALITY RATIOS* FROM ALL CAUSES

Males and Married Women, Ages 20-64 Years. England and Wales, 1949-53 and 1930-32

Social Class	Males†		Married Women‡	
	1949-53¶	1930-32	1949-53	1930-32
All Social Classes	100	100	100	100
Social Class I Professional	100	90	96	81
II Intermediate	90	94	88	89
III Skilled workers	101	97	101	99
IV Partly skilled workers	104	102	104	103
V Unskilled workers	118	111	110	113

*The ratio between the number of deaths that actually occurred to the number expected; expected deaths for males and for married women respectively were determined from the death rates by age among all males and among all married women.

†Includes noncivilians.

‡Married women by class of husband.

¶Adjusted to conform approximately with the social class occupational structure of 1931.

Source: The Registrar General's Decennial Supplement, England and Wales, 1951, *Occupational Mortality*, Part II, Volume 1. London, 1958.

studied the mortality experienced by the wives of men in the several social classes; for the most part, the wife shares the mode of life but not the occupational hazards of her husband. As the table shows, the pattern of mortality among the wives is very similar to that for the men. In 1930-32, the Standardized Mortality Ratios among married women aged 20-64 years increased progressively from Social Class I to Social Class V. In the recent study, the lowest mortality for wives, as for men, was recorded in Social Class II.

A number of important causes of death show a rise in the Standardized Mortality Ratio in passing from the professional and managerial occupations to the unskilled occupations, but for some causes the mortality is highest in the upper social classes. Some of the infectious diseases show a marked upward gradient in mortality from the highest to the lowest social class. Thus, for tuberculosis the Standardized Mortality Ratio among men in 1949-53 increased from 59 in Social Class I to 141 in Social Class V. Similar increases were recorded for influenza, pneumonia, and bronchitis. Among the other causes which showed an inverse relation between mortality and social class were cancer of the lung, chronic endocarditis, ulcers of the stomach and duodenum, and motor vehicle accidents.

On the other hand, coronary artery disease, cerebral hemorrhage, cirrhosis of the liver, and gallbladder disorders are among the diseases which show a decrease in mortality with descent in social class among men. For coronary artery disease the Standardized Mortality Ratio decreased steadily from 147 in Social Class I to 89 in Social Class V; this gradation did not occur among the wives, however.

MORTALITY FROM SELECTED CAUSES

Industrial Policyholders, Metropolitan Life Insurance Company
September 1959

Cause of Death	Annual Rate per 100,000 Policyholders*				
	September		Year to Date		
	1959†	1958	1958†	1958	1957
All Causes	618.2	612.7	673.4	673.2	646.1
Tuberculosis (all forms)	6.0	7.3	5.8	7.2	6.8
Communicable diseases of childhood	0.1	0.1	0.1	0.2	0.2
Acute poliomyelitis	0.6	0.3	0.1	0.1	0.1
Malignant neoplasms	135.3	140.9	142.8	140.4	136.5
Digestive system	43.7	48.5	48.7	46.9	47.7
Respiratory system	21.1	21.0	21.5	19.9	19.1
Diabetes mellitus	12.0	12.7	15.1	15.7	14.8
Diseases of the cardiovascular-renal system	320.9	316.4	360.0	357.3	344.0
Vascular lesions, central nervous system	63.9	59.5	68.6	67.2	66.0
Diseases of heart	233.2	235.1	264.9	264.7	252.7
Chronic rheumatic heart disease	10.1	9.7	10.9	11.6	11.2
Arteriosclerotic and degenerative heart disease	185.7	188.4	210.2	209.7	197.5
Diseases of coronary arteries	115.7	108.1	125.6	119.7	112.4
Hypertension with heart disease	26.5	26.7	31.4	32.5	33.8
Other diseases of heart	11.0	10.4	12.4	11.0	10.2
Nephritis and nephrosis	6.6	5.5	7.4	7.4	7.9
Pneumonia and influenza	14.1	13.0	19.2	22.1	15.0
Complications of pregnancy, childbirth	1.3	0.8	0.7	0.9	0.9
Suicide	5.0	6.6	6.6	6.1	5.7
Homicide	2.8	3.0	2.8	2.8	2.9
Accidents—total	34.7	36.2	33.7	34.4	35.2
Motor vehicle	14.6	15.2	14.3	14.6	15.0
All other causes	85.4	75.4	86.5	86.0	84.0

*These death rates relate to persons insured under Industrial premium-paying policies, persons with Ordinary Monthly Premium policies for less than $1,000, and persons with Debit Book Ordinary policies for $2,000 or less.

†Beginning with January 1959, deaths have been classified according to the Seventh Revision of the International List of Causes of Death. Consequently, the death rates for individual causes in 1959 are not strictly comparable with those for earlier periods. Rates for 1959 are provisional.

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Correspondence relating to the BULLETIN may be addressed to:

The Editor
STATISTICAL BULLETIN
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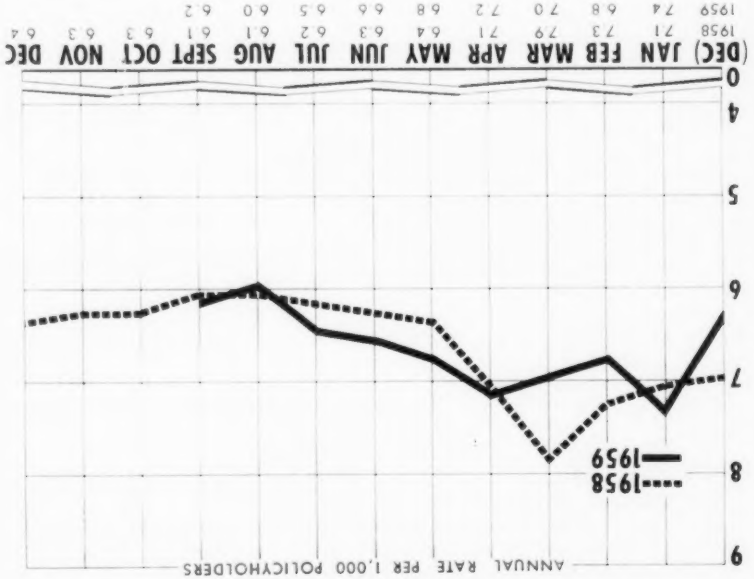

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